



IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

Court Reference: **COR 2019 1610**

FINDING INTO DEATH WITHOUT INQUEST

Form 38 Rule 60(2)

Section 67 of the Coroners Act 2008

Findings of:	MR JOHN OLLE, CORONER
Deceased:	BRUCE JOHN CAMP
Date of birth:	3 JUNE 1948
Date of death:	31 MARCH 2019
Cause of death:	I(a) PULMONARY THROMBOEMBOLUS I(b) DEEP VEIN THROMBOSIS
Place of death:	5 HENDERSON COURT BUNDOORA VICTORIA 3083

HIS HONOUR:

BACKGROUND

1. Bruce John Camp was born on 3 June 1948. He was 70 years old at the time of his death. He had an intellectual disability and lived at the Plenty Residential Services in Bundoora.
2. Bruce was diagnosed with dermatitis, blepharitis, osteoporosis and he had a history of hypertension and shortness of breath.

THE PURPOSE OF A CORONIAL INVESTIGATION

3. Bruce's death constituted a '*reportable death*' under the *Coroners Act 2008* (Vic), as immediately before death he was a person placed under the care of the Secretary to the Department of Health and Human Services ('DHHS').¹ Ordinarily, a coroner must hold an inquest into a death if the death or cause of death occurred in Victoria and the deceased person was immediately before death a person placed in custody or care.² However, a coroner is not required to hold an inquest if they consider that the death was due to natural causes.³
4. The jurisdiction of the Coroners Court of Victoria is inquisitorial⁴. The purpose of a coronial investigation is independently to investigate a reportable death to ascertain, if possible, the identity of the deceased person, the cause of death and the circumstances in which death occurred.
5. It is not the role of the coroner to lay or apportion blame, but to establish the facts.⁵ It is not the coroner's role to determine criminal or civil liability arising from the death under investigation, or to determine disciplinary matters.
6. The "cause of death" refers to the medical cause of death, incorporating where possible, the mode or mechanism of death.
7. For coronial purposes, the circumstances in which death occurred refers to the context or background and surrounding circumstances of the death. Rather than being a consideration of all circumstances which might form part of a narrative culminating in the death, it is

¹ Section 4, definition of 'Reportable death', *Coroners Act 2008*; Section 4, definition of 'Person placed in custody or care', *Coroners Act 2008*.

² Section 52(2)(b) *Coroners Act 2008*.

³ Section 52(3A), *Coroners Act 2008*.

⁴ Section 89(4) *Coroners Act 2008*.

⁵ *Keown v Khan* (1999) 1 VR 69.

confined to those circumstances which are sufficiently proximate and causally relevant to the death.

8. The broader purpose of coronial investigations is to contribute to a reduction in the number of preventable deaths, both through the observations made in the investigation findings and by the making of recommendations by coroners. This is generally referred to as the 'prevention' role.
9. Coroners are also empowered:
 - (a) to report to the Attorney-General on a death;
 - (b) to comment on any matter connected with the death they have investigated, including matters of public health or safety and the administration of justice; and
 - (c) to make recommendations to any Minister or public statutory authority on any matter connected with the death, including public health or safety or the administration of justice. These powers are the vehicles by which the prevention role may be advanced.
10. All coronial findings must be made based on proof of relevant facts on the balance of probabilities. In determining these matters, I am guided by the principles enunciated in *Briginshaw v Briginshaw*.⁶ The effect of this and similar authorities is that coroners should not make adverse findings against, or comments about individuals, unless the evidence provides a comfortable level of satisfaction that they caused or contributed to the death.

MATTERS IN WHICH THE CORONER MUST, IF POSSIBLE, MAKE A FINDING

Identity of the Deceased pursuant to section 67(1)(a) of the *Coroners Act 2008*

11. Bruce Camp was visually identified by his carer Jayaratne Bodahennadi on 31 March 2019. Identity is not disputed and requires no further investigation.

⁶ (1938) 60 CLR 336.

Medical cause of death pursuant to section 67(1)(b) of the *Coroners Act 2008*

12. On 2 April 2019, Dr Malcolm Dodd, Senior Forensic Pathologist at the Victorian Institute of Forensic Medicine, conducted an examination on Bruce's body and provided a written report dated 25 June 2019, concluding a reasonable cause of death to be "I(a) Pulmonary thromboembolus I(b) Deep vein thrombosis". I accept his opinion in relation to the cause of death.
13. Toxicological analysis of post mortem specimens detected the metabolite of risperidone⁷, hydroxyrisperidone (~ 13 ng/mL) and olanzapine⁸ (~0.02 mg/L).
14. Dr Dodd noted the immediate cause of death was a large saddle type pulmonary thromboembolus which appeared to have originated from a right deep calf vein. Deep vein thrombosis (**DVT**) may lead to detachment allowing the thrombus to flow into the lung via the vena cava to cause impaction into the pulmonary artery trunk, leading to acute right heart strain and cardiac arrest. The underlying cause for the deep vein thrombus formation is unclear. DVT may occur during periods of relative immobility.
15. Dr Dodd commented that there was no evidence to suggest the death was due to anything other than natural causes.

Circumstances in which the death occurred pursuant to section 67(1)(c) of the *Coroners Act 2008*

16. On 29 March 2019, Bruce saw a general practitioner at the Alpha Medical Clinic (**the Clinic**) in Mill Park with his carer, for abdominal pain. The general practitioner noted there was no fever and no urinary symptoms. Bruce was prescribed Movicol and red flag symptoms were explained to him. He and his carer were advised that if these symptoms developed, Bruce was to seek immediate medical attention. On 30 March 2019, a follow up appointment was made at the Clinic for 9.15am on Sunday 1 April 2019.
17. At approximately 4.00am on 31 March 2019, Bruce awoke and asked if he could have a coffee. He sat in the lounge with a carer and he said he had a sore stomach and patted his abdomen. Bruce then requested a bucket, but he did not vomit and then asked for water. The carer noticed that Bruce was breathing heavily and then he collapsed on the couch on

⁷ Risperidone is an atypical antipsychotic drug effective against the positive and negative symptoms of schizophrenia.

⁸ Olanzapine is clinically indicated for mood stabilization and as an anti-manic drug.

his left side and became unresponsive. Emergency Services were called, and staff were instructed to begin cardio pulmonary resuscitation (**CPR**). Ambulance Paramedics arrived and continued with CPR, however they were unable to revive him. Bruce was declared deceased at 5.05am. Police arrived shortly afterwards.

FINDINGS

18. Having investigated Bruce John Camp's death and having considered all of the available evidence, I am satisfied that no further investigation is required.
19. I find that the care provided to Bruce John Camp by the Department of Health and Human Services did not contribute to his death.
20. I make the following findings, pursuant to section 67(1) of the *Coroners Act 2008*:
 - (a) that the identity of the deceased was Bruce John Camp, born 3 June 1948;
 - (b) that Bruce John Camp died on 31 March 2019, at 5 Henderson Court, Bundoora, Victoria from pulmonary thromboembolus and deep vein thrombosis; and
 - (c) that the death occurred in the circumstances described in the paragraphs above.
21. I convey my sincerest sympathy to Bruce's family and friends.
22. Pursuant to section 73(1B) of the *Coroners Act 2008*, I order that this Finding be published on the internet.

23. I direct that a copy of this finding be provided to the following:

- (a) Bruce's family, senior next of kin;
- (b) Investigating Member, Victoria Police; and
- (c) Interested Parties.

Signature:

MR JOHN OLLE
CORONER

Date: 4 February 2020

